The Secretary for Health Services
COMMONWEALTH OF KENTUCKY
275 EAST MAIN STREET
FRANKFORT KENTUCKY 40621-0001
(502) 564-7042

PAUL E. PATTON
GOVERNOR

MARCIA R. MORGAN
SECRETARY

June 19, 2002

A-5
Chiropractor Providers (85)

Dear Chiropractor:

In the fall of 2001, the Department for Medicaid Services underwent an extensive reorganization. It is the Departments' belief that these changes will be beneficial to both providers and recipients. We appreciate your patience as we work through some of the issues related to reorganization. For your convenience the Department now has an informational website, which you may access at http://chs.state.ky.us//dms. This site contains regulations, *The Department's Resource Directory*, fee schedules and other information.

The Department for Medicaid Services Chiropractic program was implemented with regulation 907 KAR 3:120E on July 14, 2000. Initially all Chiropractic procedures required prior authorization. Effective September 26, 2000, regulation 907KAR 3:125E was promulgated which stated the initial twelve chiropractic contacts did not require prior authorization. If there was a medically necessary need to continue treatment beyond the first twelve contacts by the same provider and same diagnosis a prior authorization was required to be obtained unless a six month interval has occurred since the last chiropractic visit for the same diagnosis.

The current regulation 907 KAR 3:125, *Chiropractic Services and Reimbursement*, effective March 6, 2001 states prior authorization from the department shall be required for reimbursement of a covered service provided during a chiropractor-recipient face to face contact with the same provider occurring after the initial twelve (12)

contacts. The implementation of the current regulation deleted the phrase "associated with the same injury or medical condition". Therefore and henceforth, all chiropractor/recipient contacts after the initial twelve requires prior authorization unless there has been an interval of at least six months since the last service was provided. The regulation also states a medically-necessary chiropractic service shall be covered to the extent, subject to the service and reimbursement limitation, that the same service is covered by the department for a physician in 907 KAR 3:005 *Physicians' Services* and 907 KAR 3:010 *Reimbursement for Physicians' Services.* If you need a copy of the *Physicians'* Services Manual please contact Unisys Provider Enrollment at 877-838-5085. If you need a copy of the Physician regulations, they may be accessed on the website. For your convenience, we have enclosed the Chiropractic regulation, please review to ensure your compliance with the policies and procedures related to your program.

In summary the first regulation, 907KAR 3:120E, required all procedures to be prior authorized. The second regulation, 907KAR 3:125E, required prior authorization for all visits that exceeded the initial twelve contacts for the same diagnosis unless six-month interval had occurred since the last visit. Therefore, due to the difficulty of monitoring the visits and diagnosis code logic and achieving utilization management efficiency, 907KAR 3:125 was implemented, requiring prior authorization for all contacts after the initial twelve contacts, unless an interval of six months had occurred since the last visit.

If you have questions regarding claims processing or billing information please call Unisys, our fiscal agent at 800-807-1232. If you have policy questions contact the Specialty Services Branch at 502-564-2687.

Sincerely,

Marcia R. Morgan
Secretary

Enclosures

CABINET FOR HEALTH SERVICES

Department for Medicaid Services

Division of Physical Health

907 KAR 3:125. Chiropractic services and reimbursement.

RELATES TO: KRS 312.015, 312.017, 42 CFR 440.230, 441 Subpart B, 42 USC 1396d(r)

STATUTORY AUTHORITY: KRS 194A.030(3), 194A.050, 205.520, 205.560

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520 authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the provisions relating to chiropractic services for which payment shall be made by the Medicaid Program on behalf of both the categorically needy and the medically needy.

Section 1. Definitions. (1) "Chiropractic service" means the diagnosis and the therapeutic adjustment or manipulation of the subluxations of the articulations of the human spine and its adjacent tissues performed by, and within the scope of licensure of, a licensed chiropractor in accordance with KRS 312.015 and 312.017.

(2) "Chiropractor" is defined in KRS 312.015(3).

(3) "Current procedural terminology code" or "CPT code" means the identifying code used by the department for reporting a medical service or procedure.

(4) "Department" means the Department for Medicaid Services or its designated agent.

(5) "Medically necessary" or "medical necessity" means that a covered benefit shall be:

(a) Provided in accordance with 42 CFR 440.230;

(b) Reasonable and required to identify, diagnose, treat, correct, cure, ameliorate, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy;

(c) Clinically appropriate in terms of amount, scope, and duration based on generally accepted standards of good medical practice;

(d) Provided for medical reasons rather than primarily for the convenience of a recipient, caregiver, or provider;

(e) Provided in the most appropriate location, with regard to generally accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided;

(f) Needed, if used in reference to an emergency medical service, to evaluate or stabilize an existing emergency medical condition that is found to exist using the prudent layperson standard; and

(g) Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in 42 USC 1396d(r) and 42 CFR 441 Subpart B for eligible recipients under twenty-one (21) years of age.

(6) "Usual and customary charge" means the uniform amount that a medical provider charges to a private-pay patient or third-party payor in the majority of cases for a specific medical procedure or service.

Section 2. Covered Services. (1) A covered chiropractic service shall include the following:

(a) An evaluation and management service;

(b) Chiropractic manipulative treatment;

(c) Diagnostic X-rays;

(d) Application of a hot or cold pack to one (1) or more areas;

(e) Application of mechanical traction to one (1) or more areas;

(f) Application of electrical stimulation to one (1) or more areas; and

(g) Application of ultrasound to one (1) or more areas.

(2) Except as specified in Section 3 of this administrative regulation, a medically-necessary chiropractic service shall be covered to the extent, and subject to the service and reimbursement limitations, that the same service is covered by the department for a physician and shall be reported using:

(a) An evaluation and management CPT code;

(b) A chiropractic manipulative treatment CPT code;

(c) A diagnostic X-ray CPT code; or

(d) Physical modality application CPT codes for the following:

1. Application of a hot or cold pack to one (1) or more areas;

2. Application of mechanical traction to one (1) or more areas;

3. Application of electrical stimulation to one (1) or more areas; and

4. Application of ultrasound to one (1) or more areas.

(3) Coverage for a chiropractic service shall be based on medical necessity.

Section 3. Prior Authorization. (1) Prior authorization from the department shall be required for reimbursement of a covered service, specified in Section 2 of this administrative regulation, provided during a chiropractor-recipient face-to-face contact with the same provider occurring after the initial twelve (12) contacts. If there has been an interval of at least six (6) months since the last chiropractor-recipient face-to-face contact with the same provider, up to twelve (12) additional chiropractor-recipient face-to-face contacts shall be reimbursed, if medically necessary, without prior authorization from the department.

(2) A chiropractor shall request prior authorization by mailing or faxing the following information to the department:

(a) A completed Kentucky Form MAP-810, Chiropractic Prior Authorization Form; and

(b) If requested by the department, additional information required to establish medical necessity.

Section 4. Reimbursement for Covered Services. (1) A charge for a chiropractic service submitted to the department for payment shall not exceed the usual and customary charge to a private-pay patient or third-party payor for an identical procedure or service.

(2) For reimbursement of a covered service, a chiropractor shall be paid the lessor of the chiropractor's usual and customary actual billed charge or an amount determined in accordance with the physician fee schedule established in 907 KAR 3:010.

Section 5. Conditions for Provider Participation. A participating chiropractor shall:

(1) Be licensed as a chiropractor in Kentucky or in the geographic location in which chiropractic services are provided;

(2) Have an active Medicare provider number; and

(3) Meet the requirements for provider participation in the Kentucky Medicaid Program in accordance with 907 KAR 1:671, 907 KAR 1:672 and 907 KAR 1:673.

Section 6. Appeal Rights. (1) An appeal of a negative action taken by the department regarding a Medicaid recipient shall be in accordance with 907 KAR 1:563.

(2) An appeal of a negative action taken by the department regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

(3) An appeal of a negative action taken by the department regarding a Medicaid provider shall be in accordance with 907 KAR 1:671.

Section 7. Incorporation by Reference Material. (1) "Ky. Form MAP-810, Chiropractic Prior Authorization Form, September 26, 2000 edition," is incorporated by reference.

(2) The material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky, 40621, Monday through Friday, 8 a.m. to 4:30 p.m. (27 Ky.R. 2015; Am. 2487; eff. 3-6-2001.)

Dennis Boyd
Commissioner

Effective Date: March 6, 2001

CABINET FOR HEALTH SERVICES

Department for Medicaid Services

Division of Physical Health

907 KAR 3:005. Physicians' services.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 194A.030, 194A.050, 42 CFR 440.50, 415.152, 415.174, 415.184

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520 authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the provisions relating to physicians' services for which payment shall be made by the Medicaid Program on behalf of both the categorically needy and the medically needy.

Section 1. Physicians' Services. (1) Except as provided in subsection (2) of this section, a covered service shall be a service furnished by a physician through direct physician-patient interaction in the office, the patient's home, a hospital, nursing facility or elsewhere.

(2) A covered service shall include a service furnished by a resident under the medical direction of a teaching physician in accordance with 42 CFR Part 415.

(3) A physician assistant shall be considered the agent of a supervising physician with regard to coverage of a practice-related activity performed within his scope of certification in accordance with 201 KAR 9:175.

(4) For purposes of the Medicaid Program, an oral surgeon shall be:

(a) Treated in the same manner as a physician with regard to coverage for services within his scope of licensed practice; and

(b) Included in a reference to a physician, unless the context in which it is used is to the contrary.

(5) A service which is medically necessary, appropriate and related to the diagnosis and treatment of illness or injury shall be covered with the exception of those services established in Section IV, F, of the Physician's Manual incorporated by reference in this administrative regulation.

Section 2. Additional Limitations. (1) A patient placed in "lock-in" status due to over-utilization shall receive a service from his lock-in provider except in the case of emergency or if he receives a referral from his lock-in provider.

(2) Laboratory procedures.

(a) A laboratory procedure performed in a physician's office shall be limited to a procedure for which the physician has been certified in accordance with 42 CFR Part 493 and KRS 205.520.

(b) The professional component of a physician laboratory procedure performed by a board certified pathologist in a hospital setting or an outpatient surgical clinic shall be

covered if the physician has an agreement with the hospital or outpatient surgical clinic for the provision of laboratory procedures.

(3) The cost of a preparation used in an injection shall not be considered a covered benefit, except as specified in Section IV.13 of the Physician Manual.

(4) A telephone contact with a patient shall not be considered a covered benefit.

(5) A service performed or a recipient contact made exclusively by a nurse or another physician's employee shall not be covered under the physicians' services component.

Section 3. Material Incorporated by Reference. (1) The "Physician Manual", March, 1999 edition, is incorporated by reference.

(2) This material may be inspected, copied or obtained at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 406021, Monday through Friday, 8 a.m. to 4:30 p.m. (23 Ky.R. 1308; eff. 9-18-96; Am. 25 Ky.R. 1737; 2574; eff. 5-19-99.)

Effective Date: May 19, 1999

CABINET FOR HEALTH SERVICES

Department for Medicaid Services

Division of Financial Management

907 KAR 3:010. Reimbursement for physicians' services.

RELATES TO: KRS 205.550

STATUTORY AUTHORITY: KRS 194A.030(3), 194A.050(1), 205.520(3), 42 CFR 440.50, 447 Subpart B, 42 USC 1396a, b, c, d, s

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the method of reimbursement for physicians' services.

Section 1. Definitions. (1) "Department" means the Department for Medicaid Services or its designated agent.

(2) "EPSDT" means early and periodic screening, diagnosis, and treatment.

(3) "Resource-based relative value scale (RBRVS) unit" means a value based on the service which takes into consideration the physicians' work, practice expenses, liability insurance, and a geographic factor based on the costs of staffing and other resources required to provide the service in an area relative to national average price.

(4) "Screening" means the review of the health and health-related condition of a recipi

ent by a physician to determine if further diagnosis or treatment is needed.

(5) "Usual and customary charge" means a uniform amount which the medical provider charges in the majority of cases for a specific medical procedure or service.

Section 2. Reimbursement. (1) Except as specified in Section 3 of this administrative regulation, payment for a covered physician's service shall be based on the physician's usual and customary actual billed charges up to the fixed upper limit per procedure established by the department using a Kentucky Medicaid Fee Schedule developed from a resource-based relative value scale (RBRVS). If there is not an RBRVS based fee, the payment shall be sixty-five (65) percent of the usual and customary actual billed charge.

(2) A RBRVS unit shall be multiplied by a dollar conversion factor to arrive at the fixed upper limit. The dollar conversion factors shall be as follows:

Types of Service	Kentucky Conversion Factor
Deliveries	Not Applicable
Anesthesia (except Delivery-related)	$29.02
All Other Services	$29.67

Section 3. Reimbursement Exceptions. The following reimbursement exceptions shall apply.

(1)(a) The department shall reimburse a physician a three (3) dollar and thirty (30) cent administration fee for a vaccine administered to a Medicaid recipient under the age of twenty-one (21) up to three (3) administrations per physician, per recipient, per date of service.

(b) The department shall not reimburse a physician for the cost of a vaccine that is available free through the Vaccines for Children Program in accordance with 42 USC 1396s.

(c) There shall not be a limit on the number of administration fees for injectable anti-cancer drugs for which a physician may receive reimbursement per recipient per date of service.

(2)(a) A payment for the following specified obstetrical services shall be reimbursed the lesser of:

1. The actual billed charge; or

2. A standard fixed fee paid by type of procedure.

(b) The obstetrical services and standard fixed fees shall be:

1. Vaginal delivery only, $870;

2. Vaginal delivery including postpartum care, $900;

3. Cesarean delivery only, $870; and

4. Cesarean delivery including postpartum care, $900.

(3)(a) For a delivery-related anesthesia service, a physician shall be reimbursed the lesser of:

1. The actual billed charge; or

2. A standard fixed fee paid by type of procedure.

(b) Delivery-related anesthesia procedures and standard fixed fees shall be:

1. Vaginal delivery, $200;

2. Epidural single, $315;

3. Epidural continuous, $335; and

4. Cesarean section, $320.

(4) Payment for a service provided to an individual eligible for coverage under Medicare Part B shall be made in accordance with 907 KAR 1:006.

(5) A family practice physician practicing in a geographic area with no more than one (1) primary care physician per 5,000 population, shall be reimbursed as specified in KRS 205.560(10).

(6) A physician laboratory service shall be reimbursed at the Medicare allowable payment rate. For a laboratory service with no established Medicare allowable payment rate, the payment shall be sixty-five (65) percent of the usual and customary actual billed charge.

(7) A payment for an injection procedure for chemonucleolysis of a lumbar intervertebral disk shall be the lesser of:

(a) The actual billed charge; or

(b) A fixed upper limit of $793.50.

(8) Certain injectable antibiotics and antineoplastics, and contraceptives shall be reimbursed at the lesser of:

(a) The actual billed charge; or

(b) The average wholesale price of the medication supply minus ten (10) percent.

(9) For a practice-related service provided by a physician assistant, the participating physician shall be reimbursed at the lesser of:

(a) The usual and customary actual billed charge; or

(b) Seventy-five (75) percent of the physician's fixed upper limit per procedure.

(10) Reimbursement for a screening service provided to a recipient under the age of

twenty-one (21) shall be in accordance with the following:

(a) Except the fifth year (kindergarten examination) and twelfth year (sixth grade examination), the fee for a complete screening, which shall include all items or procedures listed in 907 KAR 1:034, Section 3, appropriate to the age and health history of the recipient shall be seventy (70) dollars per recipient screened;

(b) For a complete screening for the fifth and 12th years, the fee shall be ninety (90) dollars per recipient screened;

(c) For a partial screening, which shall include at least a health history and unclothed physical examination, the fee shall be thirty (30) dollars per recipient screened;

(d) For completion of a partial screening with some items or procedures appropriate to the age and health history of the recipient provided as a follow-up to a partial screening as established in paragraph (c) of this subsection, the fee shall be forty (40) dollars per recipient screened;

(e) For an interperiodic screen, which shall be medically necessary to determine the existence of a suspected physical or mental illness and in addition to the regular periodicity schedule screenings, the fee shall be thirty (30) dollars per recipient screened; and

(f) An amount payable to a physician for a service in accordance with this subsection shall not exceed the usual and customary charge of the provider for the service.

Section 4. Supplemental Payments. (1) In addition to a payment made pursuant to Sections 2 and 3 of this administrative regulation, the department shall make a supplemental payment to a medical school faculty physician employed by a state-supported school of medicine that is part of a university health care system that includes:

(a) A teaching hospital;

(b) A state-owned pediatric teaching hospital; or

(c) An affiliation agreement with a pediatric teaching hospital.

(2) The supplemental payment shall be made for a service provided on or after April 2, 2001:

(a) In an amount which when combined with other payments made in accordance with this administrative regulation, does not exceed the physician's charge for a service he has provided:

1. As a member of the medical school faculty; and

2. For which the payment is made directly or indirectly to the medical school;

(b) Based on the funding made available through an intergovernmental transfer of funds for this purpose by a state-supported school of medicine meeting the criteria established in subsection (1) of this section; and

(c) On a quarterly basis.

Section 5. Appeal Rights. (1) An appeal of a negative action taken by the department regarding a Medicaid beneficiary shall be in accordance with 907 KAR 1:563.

(2) An appeal of a negative action taken by the department regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

(3) An appeal of a negative action taken by the department regarding a Medicaid provider shall be in accordance with 907 KAR 1:671. (23 Ky.R. 1309; eff. 9-18-96; Am. 25 Ky.R. 1739; 2575; eff. 5-19-99; 27 Ky.R. 2596; eff. 5-14-2001; 28 Ky.R. 985; eff. 12-19-2001.)

Effective Date: December 19, 2001